# Part II

# Section III

# *Crisis Stabilization Service Standards for Adults*

**PROVIDER MANUAL**
**FOR**
**COMMUNITY MENTAL HEALTH,**
**DEVELOPMENTAL DISABILITIES AND**
**ADDICTIVE DISEASES**
**PROVIDERS**
**FOR**
**THE DIVISION OF MENTAL HEALTH,**
**DEVELOPMENTAL DISABILITIES**
**AND**
**ADDICTIVE DISEASES**


**JULY 2006**

**DEPARTMENT OF HUMAN RESOURCES**
**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND ADDICTIVE DISEASES**

# REQUIREMENTS FOR CRISIS STABILIZATION PROGRAMS
# Operated by COMMUNITY SERVICE BOARDS
# (aka Standards for Crisis Stabilization Programs)

**Effective July 1, 2001**

Crisis Stabilization Program standards for adults are incorporated by reference into those found in the State of Georgia Department of Hyman Resources Division of Mental Health, Mental Retardation & Substance Abuse document entitled " Standards for All Providers".

The Crisis Stabilization Program standards document has been footnoted to indicate modifications and additions to the standards since their inception. Crisis Stabilization Program standards that arose from issues resulting from the Certificate of Need concern addressed in the "Letter of Agreement" between the Department of Community Health and DHR Division of MHDDAD, signed on the 28th day of February, 2001 by George P. A. Newby, representing DCH and by Jerry Lovrien, representing DHR, have not been modified and may be modified only pursuant to agreement between DHR and DCH.

## SSr 11.1. DESCRIPTION OF THE PROGRAM

**SSr 11.1(a). The Crisis Stabilization Program is a medically monitored short-term residential service operated by the Community Service Board[4] for the purpose of providing psychiatric stabilization and detoxification services. The crisis stabilization program must be designated by the Department as both an emergency receiving facility and an evaluating facility.**

*Interpretive guideline 1:* The department may designate [as emergency receiving, evaluating and treatment facilities] any private facility or such portion of a certified community mental health and substance abuse program which complies with the standards for a CSP within the State of Georgia at the request of or with the consent of the governing officers of such facility. Rules of DHR MHMRSA ERETF 290-4-1-.02(a). Et. Seq.

*Interpretive guideline 2:* As defined in the Rules of DHR MHMRSA ERETF 290-4-1-.01(b), the term "Crisis Stabilization Program ("CSP") means a short term residential program operated as a part of a comprehensive community mental health and substance abuse program [operated by a Community Service Board or by a Divsion of MHDDAD state hospital facility][4] for the purpose of providing psychiatric stabilization or detoxification services, which complies with applicable standards in the "Standards for Community Mental Health, Developmental Disabilities and Addictive Diseases Services" [DHR Division of MHDDAD " Standards for All

[4] CSP's may be state operated effective FY04

Providers" contained within the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers Under Contract with the Division of MHDDAD*].

*Interpretive guideline 3:* Crisis stabilization programs are state supported residential services provided as a part of a Community Service Board[4] and designed to serve as a first line alternative to hospitalization in state hospitals, offering psychiatric stabilization and detoxification services on a short term basis.

*Interpretive guideline 4:* The target population served in the CSP is adults (age 18 or older) with severe and persistent mental illness, persons with substance related disorders and persons with co-occurring mental health and substance use needs.

*Interpretive guideline 5:* Emancipated minors and juveniles who are age 17 may be served within these programs when their need for stabilization can be met by the CSP, when they do not need specialized child and adolescent services, and when their life circumstances demonstrate they are more appropriately served in an adult environment. Such admissions must be approved by the Medical Director.

*Interpretive guideline 6:* Residential detoxification services offered within the CSP **shall not exceed** services described in Level III.7 of the *American Society for Addiction Medicine Patient Placement Criteria* (ASAM), Second Edition, April 2001.

*Interpretive guideline 7:* NOTE: Twenty-four hour residential services offering detoxification ONLY shall be licensed by the Georgia Department of Human Resources Office of Regulatory Services under the "Rules of Department of Human Resources Chapter 290-4-2: Drug Abuse Treatment and Education Programs". These CSP standards shall not apply.

*Interpretive guideline 8:* Psychiatric stabilization services offered within the CSP **shall not exceed** services described in Level Six of the *Level of Care Utilization System for Psychiatric and Addiction Services, Adult Version 2000* (LOCUS), published by the American Association of Community Psychiatrists, May 30, 2000.

*Interpretive guideline 9[2]:* The term "emergency receiving facility" means a facility designated by the department to receive patients under emergency conditions as provided in Part 1 of Article 3 of Chapter 3 or of Chapter 7 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(d).

*Interpretive guideline 10[2]:* The term "evaluating facility" means a facility designated by the department to receive patients for evaluation as provided in Part 2 of Article 3 or of Chapter 7 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(e).

*Interpretive guideline 11[2]:* Certification reviews will be conducted for physical plant, safety and food service according to the specifications outlined in the Rules for Drug Abuse

[2] Added to CSP Standards FY02

Treatment & Education Programs, Chapter 290-4-2, section .11 "Physical Plant and Safety" and section .12 "Food Service".

*Interpretive guideline 12*[6]*:* CSP's that are newly constructed or CSP's undergoing physical plant modifications after June 30, 2005 shall address safety issues to minimize the opportunity for self-harm of an individual such as, but not limited to the following:

a. Shower fixtures in bathrooms shall be flush-mounted in the wall
b. Headers supporting bathroom stalls shall be flush-mounted to the ceiling
c. There shall be two avenues of visual access into the seclusion and restraint room, one of which shall be through a window in the door to the room
d. Blind spots on the unit and in the seclusion and restraint room shall be addressed through use of convex mirrors allowing for visual access. A room used for seclusion or restraint must:
    i. Allow staff full view of the resident in all areas of the room;
    ii. Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets
e. Video cameras are not a permitted alternative to direct observation of an individual in the seclusion or restraint room
f. Doors to bedrooms shall be hung on hinges that swing both in to the room and out from the room. [7]Note that if a building is being *modified* and it is not possible for the door to swing both ways, the door should be mounted to open away from the room.

**SSr 11.1(b). The Crisis Stabilization Program shall describe its capacity to serve voluntary and involuntary clients.**

*Interpretive guideline 1*[6.1]*: The* program description of the CSP clearly describes their service mission including its capacity to carry out the emergency receiving and evaluating functions of the CSP.

**SSr 11.1(c). The Crisis Stabilization Program is NOT a designated treatment facility as defined by O.C.G.A. 37-3 and 37-7.**

*Interpretive guideline 1:* The term 'treatment facility' means a facility designated by the department to receive patients for treatment as provided in Part 3 of Article 3 of Chapter 3 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(f).

*Interpretive guideline 2:* The program description of the CSP clearly states that it is not a designated treatment facility or service.

**SSr 11.1(d). The Crisis Stabilization Program shall not use the word "inpatient" anywhere for any purpose to describe the services offered within the CSP.**

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[6] Added to CSP Standards FY06
[7] Added to CSP Standards FY07
[6.1] Modified FY06

*Interpretive guideline 1:* The program description and all other documents within the CSB and CSP shall describe the services offered within the CSP as *residential* services.

**SSr 11.1(e). The Crisis Stabilization Program shall not hold itself out as a hospital or bill as a hospital for inpatient service.**

*Interpretive guideline 1:* There is no evidence that the CSP is holding itself out as a hospital or that it is billing for hospital or inpatient services.

**SSr 11.1(f).[2] The CSP shall not operate in a manner or offer any service that brings them within the purview of Georgia's Certificate of Need (CON) Program as defined by the CON Statue and Rules (O.C.G.A. 31-6-1 et. seq. and O.C.R.R. 272-2-1 et. seq.).**

*Interpretive guideline 1:* There is no evidence that the CSP is operating in a manner or offering any service which brings them within the purview of Georgia's Certificate of Need (CON) Program.

**SSr 11.2 CERTIFICATION OF THE CRISIS STABILIZATION PROGRAM**

**SSr 11.2. The Crisis Stabilization Program shall be surveyed for compliance with State standards.**

*Interpretive guideline 1:* Any Crisis Stabilization Program (CSP), to be eligible for designation, shall be a part of a comprehensive community mental health and substance abuse program which comprehensive program has been certified by the Division of Mental Health, Developmental Disabilities and Addictive Diseases to be in compliance with: 1) Standards for Community Mental Health, Developmental Disabilities and Addictive Diseases Services [DHR Division of MHDDAD " Standards for All Providers" contained within the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers Under Contract with the Division of MHDDAD*], and 2) the Department of Human Resources Grants to Counties Policy Manual. Rules of DHR MHMRSA ERETF 290-4-1-.02(d).

*Interpretive guideline 2[6]:* Any state operated Crisis Stabilization Program (CSP), to be eligible for designation, shall be operated by an accredited and licensed (if applicable) healthcare authority and shall be certified by the Division of Mental Health, Developmental Disabilities and Addictive Diseases to be in compliance with: 1) Standards for Community Mental Health, Developmental Disabilities and Addictive Diseases Services [DHR Division of MHDDAD " Standards for All Providers" contained within the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers Under Contract with the Division of MHDDAD*].

**SSr 11.3. LINKAGES FOR CARE OF COMPLEX CARE NEEDS**

[2] Added to CSP Standards FY02
[6] Added to CSP Standards FY06

**SSr 11.3. The Crisis Stabilization Program shall have operating agreements with private and public inpatient hospitals and treatment facilities.**

*Interpretive guideline 1:* Crisis Stabilization Programs shall have documented operating agreements and referral mechanisms for psychiatric, addictive disorder and physical health care needs that are beyond the scope of the Crisis Stabilization Program and that require inpatient treatment. Operating agreements shall delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility.

*Interpretive guideline 2:* The following shall be clearly stated within the body of the operating agreements between the CSP and designated treatment facilities(s):

The purpose of clinical services provided by the CSP are psychiatric stabilization or detoxification. When it becomes evident 48 hours into the 'evaluation' legal status that a client is not stabilizing and may not stabilize quickly, arrangements shall be made to transfer the client to a designated treatment facility at that point. The transfer of the client shall take place no later than 72 hours into the 'evaluation' legal status, unless there has been a different time limit established in a written agreement with a hospital. The client may be transferred to the treatment facility on the existing 1014 or 2014 legal status. For the purposes of calculating the 48 or 72 hours, Saturdays, Sundays or holidays will not apply.

*Interpretive guideline 3:* The private facility or the CSP shall utilize available resources in the community to provide psychological tests and social work services if such services are needed for the patients and do not exist within the facility. Rules of DHR MHMRSA ERETF 290-4-1-.04(4).

**SSr 11.4. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)**

**SSr 11.4. The Crisis Stabilization Program will operate within the guidelines of EMTALA with respect to stabilization and transfer of clients.**

*Interpretive guideline 1:* The Crisis Stabilization Programs are not hospitals nor do they receive Medicare monies. However, the CSP's will operate within the guidelines of EMTALA with respect to the stabilization and transfer of clients to and from hospitals.

**SSr 11.5. LENGTH OF STAY**

**SSr.11.5[2.1]. The average annual length of stay shall not exceed five (5) days excluding Saturdays, Sundays and Holidays.**

*Interpretive guideline 1:* For any one episode of care, an individual person may not remain in a CSP beyond 10 days, excluding Saturdays, Sundays and Holidays, with the exception described in Interpretive Guideline 2 below.

[2.1] Modified FY02

*Interpretive guideline 2*[4.1]*:* A CSP must designate transitional beds separate from crisis residential beds. Clients occupying transitional beds may remain in the CSP beyond 10 days excluding Saturdays, Sundays and Holidays **only if they are in services and activities on a daily basis that indicate the individual is actively engaged in transitioning to the community**[6.1]**.** The CSP must record the date of transfer to the transitional bed(s) and the length of stay in transitional beds for each episode of transitional care. Transitional bed designation should be made using these parameters:

a) A CSP with up to 29 beds may designate one or two beds as transition beds. The total bed count for crisis beds and transition beds shall not exceed 29.
b) A CSP with up to 39[4] beds may designate up to three beds as transition beds. The total bed count shall not exceed 39.
c) A CSP with 40[4] or more beds may designate up to four additional beds as transition beds.

*Interpretive guideline 4*[2]*:* CSP's shall report census and length of stay data as required to the Division of MHDDAD for both regular and transitional CSP beds.

**SSr 11.6. ADVERTISING OF SERVICES**

**SSr.11.6. The Crisis Stabilization Program shall not advertise services offered within the CSP.**

*Interpretive guideline 1:* The Community Service Board may inform and educate the public about services offered by the CSP, but shall not advertise any of the CSP services or hold itself out in any manner as providing inpatient or hospital service.

**SSr 11.7. BILLING AND REVENUE SOURCE**

**SSr 11.7(a).**[2.1] **The primary revenue source shall be public funds.**

*Interpretive guideline 1:* Review of fund sources for the CSP will show that no less than 95% of the funding is public, including government payers.

**SSr 11.7(b). Clients are billed on a sliding fee scale basis according to their ability to pay.**

*Interpretive guideline 1:* Review of billing practices shall demonstrate that clients have been billed on a sliding fee scale basis.

**SSr 11.8. PHYSICIAN OVERSIGHT**

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[4.1] Modified FY04
[6.1] Modified FY06
[4] Added to CSP Standards FY04

[2] Added to CSP Standards FY02
[2.1] Modified FY02

**SSr 11.8(a). All services offered within the Crisis Stabilization Program shall be provided under the direction of a physician.**

*Interpretive guidelines 1:* "Physician" means any person who is licensed to practice in this State under the provisions of Article 2 of chapter 34 of Title 43, or who is employed as a physician by the United States Veterans Administration or other federal agency. Rules of DHR MHMRSA ERETF 290-4-1-.01(g).

*Interpretive guideline 2:* The active medical staff of the CSP shall include a physician who has completed at least one year of approved psychiatric residency and consultation by a psychiatrist shall be available. Rules of DHR MHMRSA ERETF 290-4-1-.04(2)

*Interpretive guideline 3:* In the event that the physician providing coverage is not a psychiatrist, arrangements shall be in place for psychiatric consultation.

**SSr 11.8(b) A physician shall conduct assessments of new clients, address client care issues and write orders as required.**

*Interpretive guideline 1:* A physician is NOT required to be on site 24 hours a day, however the physician must report to the Charge Nurse daily. A physician must be available by pager 24 hours a day and must respond to staff calls immediately, not to exceed one hour. The physician must personally report to the CSP at the request of the charge nurse.

*Interpretive guideline 2:* CSP's must have capacity to admit and discharge seven days a week.

*Interpretive guideline 3:* A physician must assess each new client within 24 hours of admission.

*Interpretive guideline 4:* Documentation by the physician shall include, at a minimum the initial evaluation of the client, resulting diagnoses and care orders, the response to care and services provided, a rationale for medications ordered or prescribed, and assessment of the client at the time of discharge.

**SSr 11.8(c). The functions performed by physician's assistants, nurse practitioners and clinical nurse specialists are within the scope allowed by state law and professional practice acts.**

*Interpretive guideline 1:* The CSP utilizing physician's assistants, nurse practitioners and clinical nurse specialists can demonstrate verbally and through documentation their implementation of agreements and procedures required by state law and professional practice acts. Renewal of Georgia Board of Nursing authorization as a nurse practitioner will coincide with the renewal of the registered professional nurse license.

**SSr 11.9. REGISTERED NURSE OVERSIGHT**

**SSr 11.9(a). The Crisis Stabilization Program shall have a position classified as a lead nurse or higher that serves as the nursing administrator.**

*Interpretive guideline 1:* The Registered Nurse designated as nursing administrator is a full-time employee of the program whose job responsibilities include, but are not limited to, clinical supervision of nursing staff and the implementation of physician's orders.

**SSr 11.9(b). The Crisis Stabilization Program shall have a Registered Nurse present within the facility at all times.**

*Interpretive guideline 1:* A Registered Nurse must be in the CSP facility at all times.

*Interpretive guideline 2:* A Registered Nurse must be the Charge Nurse at all times.

*Interpretive guideline 3:* There must be one Registered Nurse within the CSP facility for every 30 CSP facility beds.

**SSr 11.10. STAFF TO CLIENT RATIOS**

**SSr 11.10. Staff to client ratios shall be established based on the stabilization needs of clients being served.**

*Interpretive guideline 1:* The ratio of direct care staff to clients should not be less than 1:8 (including the Registered Charge Nurse).

*Interpretive guideline 2:* There shall always be at least two staff present within the CSP including the Charge Nurse.

*Interpretive guideline 3:* The utilization of licensed practical nurses shall be considered to provide technical support to the Registered Nurse.

*Interpretive guideline 4:* The functions performed by registered nurses and licensed practical nurses are within the scope allowed by State Law and professional practice acts.

**SSr 11.11. USE OF SECLUSION OR RESTRAINT**

**SSr 11.11(a). A Crisis Stabilization Program may only use restraint and seclusion as a safety intervention of last resort.**

*Interpretive guideline 1:* In all cases, the law regarding seclusion and restraint found in O.C.G.A. 37-3 and 37-7 as well as the rules and definitions found in Rules of Department of Human Resources, Mental Health, Mental Retardation and Substance Abuse Chapter 290-4-6 Patients' Rights shall apply.

*Interpretive guideline 2:* All physical restraints and seclusion shall be used solely for the purposes of providing effective treatment and protecting the safety of the patient and other persons and shall not be used as punishment [or] for the convenience of staff. Physical restraints and seclusion should only be used when no less restrictive methods of controlling behavior which would reasonably insure the safety of the patient and other persons are feasible. Rules of DHR MHMRSA PR290-4-6-.02 (1)(c)1.

*Interpretive guideline 3*[5.1]*:* Seclusion or restraint may only be used when less restrictive interventions have been determined to be ineffective. All interventions utilized prior to the seclusion or restraint episode must be descriptively documented in the sequence used and identified as to the staff member conducting the intervention.

*Interpretive guideline 4*[5.1]*:* CSP's must have a written policy and procedure about the use of seclusion and restraint. Evidence of annual training and competency in the proper and safe use of seclusion and restraint including techniques and alternative methods for handling behavior, symptoms and situations that traditionally have been treated through the use of restraints or seclusion must be available within staff personnel files for all staff who have direct contact with clients.

*Interpretive guideline 5:* The body of the admission assessment shall contain an assessment of past trauma or abuse. The person shall also be asked how they would prefer to be approached should they become dangerous to themselves or to others. Findings from these queries shall inform the decision making process about the plan of care.

**SSr 11.11(b).[5.1] A physician or other licensed practitioner permitted by the State shall give an order for the seclusion or restraint episode within one hour of the implementation of seclusion or restraint intervention.**

*Interpretive guideline 1*[5.1]*:* The physician or Clinical Nurse Specialist (CNS) must be notified immediately of the seclusion or restraint episode. An order must be given that approves the use of the seclusion or restraint intervention, that defines specific time limits for the episode (not to exceed four (4) hours), and that states the behavioral indicators which signal the end of the episode. The restraint or seclusion episode shall be ended at the earliest possible time.

*Interpretive guideline 2*[5]*:* The treating physician must be consulted as soon as possible if the restraint or seclusion is ordered by a licensed practitioner permitted by the State who is not a physician.

**SSr 11.11(c).[5.1] A physician or other licensed practitioner permitted by the State must personally examine the client if the episode exceeds one hour of the beginning of the**

[5.1] Modified FY05
[5.1] Modified FY05

[5] Added to CSP Standards FY05

**seclusion or restraint episode or within the time frame that is consistent with federal regulations.**

*Interpretive guideline 1*[5.1]*:* The physician or CNS must personally examine the client by the end of the first hour of the seclusion or restraint episode or within the time frame consistent with current federal regulations. The findings of the examination of the client shall be documented in the client record.

*Interpretive guideline 2:* If the client is released from seclusion or restraint prior to the end of the first hour *and* prior to the personal examination of the physician or CNS, the rationale for release of the client *and* the fact that the client was not personally seen by a physician or CNS shall be fully documented within the client record.

*Interpretive guideline 3*[5.1]*:* After the order expires, a new determination for continued seclusion or restraint may be made ONLY after the client is PERSONALLY examined by a physician or CNS and may be ordered for an additional specific time episode not to exceed four (4) hours.

*Interpretive guideline 4:* After any seclusion or restraint episode, there must be a determination by the treating physician or Medical Director as to whether transfer to a treatment facility is indicated. The treating physician or Medical Director's determination must be documented within the progress notes. Justification for maintaining the client at the CSP for additional care must be contained in the physician progress note.

**SSr 11.11(d). During the seclusion or restraint episode, the person must be continuously monitored and a documentation entry to that effect be made every 15 minutes.**

*Interpretive guideline 1:* A staff member must be assigned to be present immediately outside the seclusion door when a client is secluded.

*Interpretive guideline 2:* A staff member must be assigned to be present at all times within the room and the door to the room left open when a client is restrained.

*Interpretive guideline 3:* A patient placed in physical restraints shall be checked at least every 15 minutes by staff members trained in the use of restraints, and a written record of these checks and all other activities shall be made.

*Interpretive guideline 4:* While in restraints each person should be spoken to, checked for indications of obvious physical distress, be offered liquids and an opportunity to meet his need to urinate and defecate as needed or at least every 2 hours unless the person is asleep or his condition does not permit. The restraints sites should be checked every hour for evidence of swelling or abrasion. Each hour a restraint should be removed from each limb for five minutes and then reapplied if his condition permits. A person in restraints should receive all meals available to other patients except as otherwise ordered by a physician based upon the person's

[5.1] Modified FY05

health needs and as his condition to take meals while in restraints. In all situations, the client must receive nutrition at regular meal intervals unless refused by the client. Restraints are to be discontinued when they are no longer needed to prevent a person from hurting himself or others and his medical needs allow removal.

**SSr 11.11(e). Staff shall conduct a debriefing with the client after release from seclusion or restraint.**

*Interpretive guideline 1:* The client shall have an opportunity to talk to an appropriate staff member authorized by the facility (preferably a staff member who was not involved in the incident), as soon as appropriate after release from seclusion or restraint.

*Interpretive guideline 2:* The following are potential issues to explore with the client:

- What the client remembers happening prior to their becoming angry, destructive or self injurious?
- Whether the client remembers sensory changes prior to being placed in seclusion or restraints?
- What thoughts the client has about why the client was placed in seclusion or restraint?
- How the client felt while in seclusion or restraint?
- How the client felt after being released from seclusion or restraint?
- Was there something the client did that was helpful in gaining personal control?
- Was there something the staff did that was helpful in the client gaining personal control?
- What changes could be made to assist the client in future instances when the client might lose control?

*Interpretive guideline 3:* The client responses shall be documented with pertinent intervention information incorporated within the client plan of care.

**SSr 11.11(f). The staff members involved in the seclusion or restraint episode shall receive a debriefing after the episode.**

*Interpretive guideline 1:* The staff members involved in the seclusion or restraint episode shall be interviewed immediately after the episode to determine the following information. The identified leader of the episode shall conduct the critique of the seclusion or restraint episode.

- What physical cues were present that indicated escalation of client behaviors?
- What interventions were conducted, by what staff member and in what order as the events unfolded leading up to seclusion or restraint?
- What was the client response to each intervention conducted?
- Could alternate interventions resulted in a different outcome other than seclusion or restraint?
- What did the staff involved do well?
- What could staff do differently in the future that might avoid reaching the point of a seclusion or restraint?

- What recommendations shall be documented within the client plan of care for use in future situations?

**SSr 11.12 ORGANIZATIONAL RISK AND COMPLIANCE[6]**

**SSr 11.12 The CSP has a well-defined approach for assessing its performance, for anticipating, identifying, correcting and solving problems, and for improving quality of care related to use of safety interventions of last resort.**

*Interpretive guideline1:* The CSP maintains a record of each emergency safety situation, the interventions used, and their outcomes.

*Interpretive guideline 2:* Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

*Interpretive guideline 3:* Data regarding the use of safety interventions of last resort will be aggregated and reported quarterly to the CSP management and risk management authority of the managing Community Service Board or State Hospital facility. The report shall include issues that have been addressed pursuant to review of the data, or that no action is required based on aggregate information.

**SSr 11.13 PHARMACY SERVICES**

**SSr 11.13 All pharmacy operations or services within the CSP must be licensed and under the direct supervision of a Registered Pharmacist or provided by contract with a licensed pharmacy operated by a Registered Pharmacist.**

*Interpretive guideline 1:* Pharmacy services must be provided under the license and supervision of a Registered Pharmacist who is operating under a 'retail' or 'hospital' license.

*Interpretive guideline 2:* Any request for exemptions for requirements regarding a pharmacy license must be submitted in writing to the Georgia State Board of Pharmacy.

**SSr 11.14. MEDICATION ADMINISTRATION**

**SSr 11.14 in all cases, the rules regarding medications found in Rules of Department of Human Resources, Mental Health, Mental Retardation and Substance Abuse Chapter 290-4-9 Clients' Rights shall apply**.

*Interpretive guideline 1:* Medications shall be used solely for the purposes of providing effective treatment and protecting the safety of the client and other persons and shall not be used as punishment or for the convenience of staff.

[6] Added to CSP Standards FY06

*Interpretive guideline 2*[6]*:* The CSP shall follow policies and procedures found in the Division of MHDDAD Policy 2:100, *Informed Consent for Psychotropic Medication,* concerning the use of psychotropic medications and the use of involuntary medications.[6]

**SSr 11.15. PROVISION OF INDIVIDUALIZED CARE**

**SSr 11.15. Educational and program offerings within the CSP include services to meet the individual stabilization needs of each client including co-occurring mental health and substance use needs.**

*Interpretive guideline 1:* Educational and program offerings include offerings that address issues both common and distinct to the person in psychiatric distress and to the person requiring detox from substances.

*Interpretive guideline 2:* The client clinical record will demonstrate individualized interventions based on the care needs of each person served as evidenced within the body of assessments, documentation of the progression of care and documented discharge linkages.

*Interpretive guideline 3:* Staff training records shall show evidence of annual training and competency in caring for the person with co-occurring mental health and substance use issues.

**SSr.11.16 REPORTING OF SERIOUS OCCURRENCES**[6]

**SSr.11.16. The CSP must report each serious occurrence.**

***Interpretive guideline 1:*** Serious occurrences shall be reported as specified in Policy 2:101 of the Division of MHDDAD, *Reporting and Investigating Consumer Deaths and other Serious Incidents.*

**SSr. 11.16 DESIGNATION AS A CRISIS STABILIZATION PROGRAM**

**SSr 11.16. The designation must be approved and may be withdrawn by the department. Designation is not transferable**.

*Interpretive guideline 1:* Designation as a crisis stabilization program must be approved and may be withdrawn by the department. Designation is non-transferable.

*Interpretive guideline 2:* Each designation or provisional designation shall be returned to the department in the following cases. This includes but may not be limited to:

- Change in location
- Program closure
- DHR finding of failure to comply with CSP standards
- Loss of accreditation

[6] Added to CSP Standards FY06

[6] Added to CSP Standards FY06